

## An interpretative phenomenological analysis of men's and women's coping strategy selection during early IVF treatment

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### Abstract

**Objectives:** To describe the coping strategies that men and women adopted during the early stages of in vitro fertilisation treatment, and explore why and how they selected those strategies. **Background:** Previous research has identified coping strategies used during fertility treatment and the impact of those strategies on adjustment, but not how and why individuals choose the strategies they did, which is important for understanding coping strategy use as a self-regulatory process. **Methods:** Three heterosexual couples took part in two or three individual semi-structured interviews over six months, producing fourteen accounts, which were analysed using interpretative phenomenological analysis. **Results:** The emergent themes were: *not dwelling on emotional issues; getting on with treatment; and keeping busy with other things*. Participants selected coping strategies in a conscious, deliberate way, by making comparisons with other patients and by drawing on their broader, customary ways of coping. The strategies participants adopted made sense in the context of their long-term goals as well as their short-term treatment objectives. **Conclusion:** This research shows that for these participants, shorter-term behavioural strategies were informed by longer-term goals, which is consistent with a self-regulatory approach to understanding how people cope with the stress of treatment for infertility.

### Introduction

Nine to 15% of the population experience infertility (Boivin, Griffiths, & Venetis, 2011), which is frequently considered one of the most stressful experiences couples can encounter (Greil, Slauson-Blevins, & McQuillan, 2010). Depression, anxiety, distress and reduced wellbeing have all been observed among infertile people (Beaurepaire, Jones, Thiering, & Saunders, 1994; Cousineau & Domar, 2007; Morrow, Thoreson, & Penney, 1995), although most infertile individuals appear psychologically well adjusted (Edelmann, Connolly, & Bartlett, 1994; Lord & Robertson, 2005). To reconcile those two patterns of findings and differences between the findings of qualitative and quantitative research, infertility researchers have drawn heavily on Lazarus and Folkman's (1984) transactional stress and coping theory (Dunkel-Schetter & Lobel, 1991). This model theorises stress and coping as cyclical,

moving through situation appraisal, coping resource assessment, and coping strategy outcome evaluation (Aldwin, 2007).

Research on infertility conducted within that framework has identified active, approach-oriented, problem-focused coping, planning and re-appraisal, as well as acceptance and emotional processing and expression, as more adaptive coping strategies (Berghuis & Stanton, 2002; Edelman et al., 1994; Litt et al., 1992; Lord & Robertson, 2005; Stanton et al., 1992; Terry & Hynes, 1998). Avoidance, escape coping, venting and self-blame have been recognised as strategies that increase distress (Berghuis & Stanton, 2002; Hynes, Callan, Terry, & Gallois, 1992; Litt, Tennen, Affleck, & Klock, 1992; Peterson, Newton, Rosen, & Skaggs, 2006a; Stanton, Tennen, Affleck, & Mendola, 1992; Terry & Hynes, 1998). It has been suggested that most fertility patients use adaptive coping strategies (Edelman et al., 1994; Lord & Robertson, 2005).

It is important for research on coping with infertility to consider gender and couple (dyadic) influences. Infertility usually affects a couple, and an individual's strategy choice will most likely impact their partner. Research showed that men are more likely to use distancing and self-control strategies, whereas women are more likely to use avoidance and escape strategies (Abbey, Andrews, & Halman, 1991; Peterson, Newton, Rosen, & Skaggs, 2006b; Stanton et al., 1992). Distancing strategies may benefit men but not their partner (Peterson et al., 2006b), whereas avoidant coping adversely affects both partners' coping (Peterson et al., 2009; Peterson, Pirritano, Christensen, & Schmidt, 2008). Meaning-based coping, which Folkman (1997) added to the transactional model, appears beneficial for both partners over the short- and long-term (Peterson et al., 2009, 2008).

One issue left unaddressed by most research on coping with infertility is why and how affected individuals select the coping strategies they do. Gaining an understanding of this process would help locate coping strategies as self-regulatory behaviour in the broader context of people's lives and treatment situations (Benyamini, Gozlan, & Kokia, 2004). The self-regulation model (SRM) focuses on how individuals attempt to attain their goals through the cycle of evaluation, coping strategy selection, re-evaluation and adjustment (Carver, Scheier, & Fulford, 2008). A self-regulatory framework has previously helped to understand how people managed multiple goals during treatment for infertility (Phillips, Elander, & Montague, 2014), and in this study we applied the same conceptual framework to participants' experiences of coping strategy selection during their first six months undergoing in vitro fertilisation (IVF) treatment.

## **Methods**

This was a longitudinal qualitative investigation of individuals' experiences using interpretative phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009). IPA draws on phenomenology, hermeneutics and idiography to understand how small, homogeneous samples make sense of their experiences (Smith, 2004). It aims to give voice to participants and produce analyses with psychological perspectives (Larkin, Watts, & Clifton, 2006). IPA studies may draw on existing theory and literature, and concepts such as social comparison, self-regulation theory, metaphor use and linguistic markers, provided the analysis stays close to the data (Smith & Osborn, 2003; Smith, 2004).

### ***Sample***

Reflecting the importance placed on considering a homogeneous sample in IPA studies (Smith, 2004) this study focused on three heterosexual couples starting IVF to conceive their first child together using their own genetic material. The couples, referred to in the analysis as Natalie and Jeremy, Judy and Matt, and Cathy and Chris, had been together for 2 to 3 years and had been trying to conceive for 1 to 2 years. Their ages ranged from early 30s to late 40s. All three couples were paying for their own fertility treatment. All the participants were previously unknown to the researchers.

### ***Procedure***

Participants were recruited through a collaborating fertility clinic and through the first author's personal contacts. A nurse at the clinic informed couples meeting the inclusion criteria about the study. The data were collected in individual semi-structured interviews conducted in person or through video-conferencing on Skype™ after participants gave written consent. Individual interviews were employed because we wished to obtain independent accounts of each couple's coping strategy selection. Repeated interviews were employed to allow insights into changes over time and to allow participants to reflect on their choice and use of different ways of coping. Baseline interviews were conducted as the couples began their first IVF cycle, with follow-up interviews six months later. One couple (Cathy and Chris) both gave a third interview after their first treatment cycle. Interviews were audio-recorded and transcribed verbatim. Open-ended questions drew on the stress and coping, infertility and IPA literature, using neutral terms like 'on a day-to-day basis, what helps you?' or 'are there things you do that make life more difficult?' Pseudonyms were used in all unsecured materials. The study protocol was approved by the University's Psychology Research Ethics Committee and the clinic Institutional Review Board.

### ***Analytic strategy***

The analysis followed Smith et al.'s (2009) guidelines. Initial coding involved reading the transcript and making notes, including observations made during interviews and transcription. Transcripts were then coded line-by-line, describing, interpreting, and noting unusual remarks and linguistic elements such as pronoun and metaphor use. Interviews were analysed in turn and in detail, following the IPA idiographic principle (Smith & Osborn, 2003), culminating in a detailed, empathic account including copious extracts. All data was coded, including contradictory extracts. Smith's (2011) standards for good quality IPA research were followed, identifying prevalent themes across the data set, ensuring all participants were represented, and showing variability of experiences within themes. The analysis presents topics occurring across most accounts that best illuminated the research question.

The first author conducted the initial data analysis, the other two authors reviewed transcripts and written analyses, and all authors discussed and agreed on the analysis. External IPA researchers audited the analysis. The researchers kept a reflective journal, which addressed Ahern's (1999) reflective questions and encouraged them to challenge their preconceptions and focus on participants' experiences.

## Analysis

Three themes emerged, representing coping strategies that all participants described: *not dwelling on emotional issues*; *getting on with treatment*; and *keeping busy with other things*. The analysis identifies how and why these strategies were chosen, and their meaning and significance to participants. Extracts are labelled with participants' pseudonyms and interview numbers ('1', '2', or '3').

### ***'It's going to hurt to get tense': Not dwelling on emotional issues***

Becoming stressed or emotional during treatment was described as a poor strategy that was unhealthy and undesirable because participants believed it reduced fertility and made successful treatment less likely:

*I'm trying not to put too much mental pressure on myself. Because I don't think that helps. Or stress. (Cathy 3)*

Cathy described '*mental pressure*' or '*stress*' as unhelpful, and implied that the mental stress originated internally rather than externally, as she put it '*on myself*'.

The men linked stress with negative physiological effects for their partner, whose '*positive and relaxed*' mental state was prioritised:

*Stressing over it is not going to help anything, because that just affects her body and stresses it out, is negative towards that, you know, so as long as she can stay somewhat positive and relaxed, and hopefully not worry about things, things will go. (Matt 2)*

Matt's description of deciding to avoid '*stressing over it*' implied a deliberate choice made in order to maximise his partner's chances of conception. In other cases, the same strategy choice of avoiding becoming stressed and emotional emerged from comparisons with others undergoing treatment:

*You see people get so caught up into the 'we have to have one' and that just doesn't seem like a healthy way to approach it. (Jeremy 2)*

Jeremy described other fertility patients he had encountered during clinic visits as carried away by their desire for a baby, which he evaluated as an unhealthy response and attributed to having a single, dominant goal: '*we have to have one*'. This negative view of emotionally-driven coping strategies is consistent with understandings of gendered coping patterns, where women tend to display (or admit to) more distress and men tend to be more action focused (Aldwin, 2007). However, female participants also observed other fertility patients, including friends and family, who they described as stressed, anxious and obsessive, and wanted to avoid similar responses themselves:

*I do have a friend who's going through it now and who just got pregnant via IVF and she was sort of the template of what I didn't want to be, she was way too invested. (Natalie 1)*

Natalie's description links observations of others with a '*template*' of a behavioural strategy that she consciously and deliberately wanted to avoid, again suggesting that coping behaviours were choices rather than automatic responses. Natalie rejected her friend's strategy despite her treatment success.

To summarise, participants attempted to avoid dwelling on emotional issues, such as *'being'* stressed and having a strong (negative) emotional response to infertility or IVF treatment, often because they linked stress with poorer fertility outcomes. Participants also made downward comparisons, or comparisons with less fortunate others (Stanton, 1992), criticising others who appeared stressed and distressed and describing them as worse off. Avoiding emotional responses was portrayed as a controllable, deliberate choice for which they could articulate rational explanations.

### ***'You find a way and do it': Getting on with treatment***

The men, particularly, saw planning or undergoing treatment as a good way to respond to infertility and treatment failure. They contrasted action with worrying or *'introspection'*:

*We figured out how we were going to try to attack the problem. I don't think there was a big introspection piece there. I was just, ok, this is reality, that if we want to have a child naturally, this is how we have to do it (Jeremy 1)*

Jeremy identified infertility as a *'problem'* to be *'attack[ed]'*, emphasising decisive action, and positioning his evaluation as factual, describing the situation as *'reality'*. Matt focused on action rather than emotions, for example when discussing a treatment failure:

*I wouldn't say bothers, it's just a question of (pause) what will we do next? (Matt 2)*

Matt downplayed being *'bother[ed]'* by the failure and highlighted the practical decision *'what will we do next?'*. Using *'just'* downplayed the initial statement, while his pause moves attention to the action related question. Both these extracts show preferences for action over emotion.

The *'action'* strategy sometimes emerged as a characteristic problem-solving approach:

*I do a practical job; I'm a practical person. I have to get from A to B, and everything I do is like that. I work like that. And um, that's sort of the way I think. (Chris 1)*

Like Jeremy, Chris framed the situation as a straightforward problem with a solution. Perceiving action as the appropriate strategy made behaviours that hindered it, such as expressing stress or strong emotions, less desirable:

*I've had life challenges; I'm acutely dyslexic, but you just kind of find a way and then you do it. It's not, I mean, if I got mired down in the difficulty of it, I probably wouldn't be able to achieve it. So, for me, it's a choice and I see it as a to-do, not as a difficulty. It's just something that has to be done (Natalie 1)*

Natalie described her strategy as *'a choice'*, contrasting action with being *'mired down in the difficulty of it'*. She used her previous experience with dyslexia to validate her choice, so whereas Chris described his approach as characteristic, Natalie attributed hers to experience. They both implicitly assumed a need for action.

This theme counterbalances the last one, with participants contrasting action with dwelling on emotional responses. Planning and undergoing treatment was suggested as the best way to tackle infertility, justifying treatment, and focusing on the next treatment step appeared helpful in responding to treatment failure.

### ***'I was getting on with things': Keeping busy with other things***

When treatment was unavailable, keeping busy with other projects was described as a good strategy, which enabled participants to achieve goals beyond pursuing parenthood. While Cathy wanted to *'get on with it [treatment]'* at her baseline interview other factors were also significant:

*I've been doing this doctorate for the last four five years and there's that part of me that wants to wait until that's done. (Cathy 1)*

Cathy wanted to balance the right time for IVF while achieving the PhD she had invested *'four five years'* in, valuing both goals. This re-emerged during her second interview, when she was finishing her thesis while awaiting a pregnancy test result. She described *'getting on with things, living life as I normally do'* (Cathy 2). Having another task helped her not dwell on waiting, and was an important goal itself.

The time between embryo transfer and pregnancy test could be a difficult waiting period for participants, but Judy described doing a *'good job of keeping myself busy, so that I don't dwell on it'* (Judy 2). Judy had no treatment-related action during this time, and valued finding other activities. In Natalie's second interview she also described keeping busy, by beginning an adoption process alongside IVF:

*It seemed like if it was going to take another few months to do the last round of IVF by the time we started and did all- everything, to start adoption so at least we burnt through 3 or 4 months of that and we kind of gave ourselves a head start, so it's like OK, now we're really only going to wait 10 months, which with the gestation period of the baby would be the equivalent. So I think when we mapped it out that way more or less it would have been the same time frame. (Natalie 2)*

Natalie's strategy for keeping busy focused on minimising the potential wait until she became a mother: *'we burnt through 3 or 4 months'* of the adoption process. Whereas Cathy's aim was to get something else completed and Judy's seemed to be an avoidance of too much thinking, Natalie's focus was on minimising the time spent waiting to become a mother. Chris, however, thought it could be possible to be too busy, reflecting again a perceived link between stress and conception:

*But you know the crazy thing is that for the last year and half, of the two years that we've been trying, Cathy's been doing this doctorate, and you never know, she might end up having one naturally in-between, you hear crazy things like that, do you know what I mean? It's just, now she's not stressed, now, going through this process, takes the pressure in a way off of trying to conceive. (Chris 2)*

Chris wondered whether the combination of *'trying'* to conceive and doing a doctorate impeded conception for Cathy. Deciding to undergo treatment *'takes the pressure...off'*, potentially allowing *'crazy things'* to happen, potentially including *'having one naturally'*.

Participants valued being able to pursue other tasks when fertility treatment paused, to attain other important goals, including those other than achieving parenthood, and those activities helped their attempts to not dwell on emotional issues associated with fertility. This strategy represented a desire to manage time efficiently, to achieve parenthood in the shortest timescale, and to pursue multiple important goals simultaneously. Avoidance may be a negative coping strategy (Berghuis & Stanton,

2002), but having other activities available seemed helpful to participants when problem-relevant activities were unavailable, allowing them to achieve other, non-fertility related, goals. Rather than avoiding thoughts of infertility, the behavioural strategies of managing time efficiently, achieving parenthood in the shortest timescale and pursuing multiple important goals simultaneously, make sense to participants in terms of successfully pursuing their ultimate goal of parenthood.

## Discussion

This study investigated strategy selection during early IVF treatment, generating three themes representing significant action-oriented or problem-solving strategies for most participants: *not dwelling on emotional issues*; *getting on with treatment*; and *keeping busy with other things*. Problem-oriented strategies for coping with infertility have been identified previously (Edelmann et al., 1994; Lord & Robertson, 2005), but this analysis provided new insights into how people made sense of their coping strategies, and the explanations they gave for their choices of ways to cope. Participants emphasised having control over their coping strategy selections, which contrasts with previous research that focused on control solely in terms of the processes and outcomes of fertility treatment (Abbey & Halman, 1995; Glover, McLellan, & Weaver, 2009; Verhaak, Smeenk, Evers, et al., 2007). Participants also described choosing and controlling their emotional responses, rather than emotions being automatic responses to their situated experiences (e.g. Newton, Sherrard, & Glavac, 1999; Verhaak, Smeenk, Nahuys, Kremer, & Braat, 2007).

Comparisons with other fertility patients, beliefs about what coping strategies were ‘good’ or ‘healthy’, and participants’ habitual problem-solving approaches all influenced strategy selection. The women, particularly, made downward comparisons with other women in treatment when describing their strategy choices. They cited other women’s responses to infertility, reflecting behaviour mentioned in the literature, such as being treatment obsessed (Greil & McQuillan, 2004), and described them as undesirable. This contrasts with research where women avoided downward comparisons in recognition of a ‘shared fate’ (Stanton, 1992, p. 398). Other research has suggested that downward comparisons help mitigate the perceived threat of a diagnosis (Senior, Smith, Michie, & Marteau, 2002; Thompson, Kent, & Smith, 2002; Turner, Barlow, & Ilbery, 2002). The present study suggests that downward comparisons may also generate positive behavioural or coping strategies; from their observations of others, participants developed concepts of adaptive and healthy behaviours.

When explaining their strategy selection, participants referred to their longer-term aims and goals, of which parenthood and biological parenthood was just one, reflecting the way that people in fertility treatment manage multiple goals (Phillips et al., 2014). Their strategy selection was also informed by the link they perceived between stress and infertility, so that they attempted to control the pressure and stress they experienced in order to improve their chances of conception. This is consistent with other studies of attitudes and beliefs about infertility (Lampman & Dowling-Guyer, 1995; Lord & Robertson, 2005), though the link between stress and conception is not actually supported by empirical data (Boivin et al., 2011).

Participants were also time conscious: they managed their time in a very deliberate way in order to achieve a positive outcome from treatment as well as to pursue goals in other areas of their lives. In

some ways, the themes 'getting on with treatment' and 'keeping busy with other things' describe complementary strategies, appropriate at different times. 'Keeping busy with other things' might be considered a negative, avoidant strategy (Berghuis & Stanton, 2002; Peterson et al., 2006a, 2006b), but seemed to be adaptive when applied during periods where there are no treatment-related actions to take. There was some evidence that participants made situation-dependent choices of coping strategy, which is consistent with the transactional model of coping (Lazarus, 1999).

Participants' descriptions of their coping strategies or behavioural approaches to fertility treatment are consistent with the self-regulation model (Leventhal, Brissette, & Leventhal, 2003). Behavioural coping strategies were selected in a very conscious, deliberate way, based on reflection and deliberation about what behavioural approaches were more or less likely to achieve participants' multiple goals. This pattern of findings supports proposals to absorb the stress-coping model into the broader self-regulation framework (Carver et al., 2008; Kraaij, Garnefski, Schroevers, Weijmer, & Helmerhorst, 2010; Leventhal, Halm, Horowitz, Leventhal, & Ozakinci, 2004).

This research has implications for therapy and patient support. The negative evaluations that female participants made of other, more emotional fertility patients, might suggest that they would find emotional support options unattractive if it grouped them with distressed women. The emphasis on problem solving described here suggests that informational or decision-making assistance might be more welcome than emotional support for some. Finally, therapy is sometimes designed to support the development of helpful coping strategies (McQueeney, Stanton, & Sigmon, 1997), but these participants felt that they were already dealing with the situation in the best way they could. Better understanding couples' different goals and established coping strategies would allow development and targeting of interventions.

To conclude, we identified three behavioural coping strategies used during early fertility treatment, and explored why and how participants developed these approaches. This adds to what was known from previous research that tends to have focused mainly on which strategies are used rather than how they are selected. Participants attempted to minimise stress and distress, and to focus on action, either to pursue treatment or other goals, depending on whether treatment options were available at that time. Long-term goals informed shorter-term behavioural strategies, which were selected in a conscious, deliberate way. Strategy choices were also informed by comparisons with others, beliefs about healthy responses, and participants' own successful problem solving strategies. Further research could explore how those strategies develop later in treatment, or adapt and evaluate coping interventions for those undergoing IVF.

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